

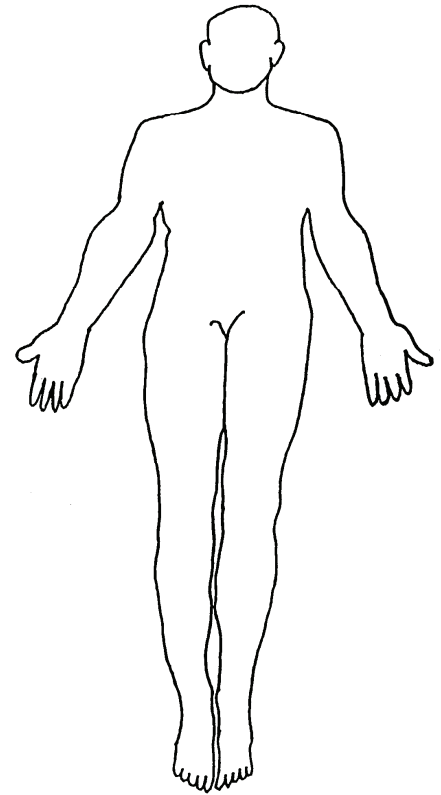
**TALLAHASSEE DIAGNOSTIC IMAGING
MRI SCREENING FORM**

PATIENT NAME: _____ **DATE:** _____

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following.

- | | | | | |
|--------------------------|-----|--------------------------|----|--|
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Cardiac pacemaker or internal pacing wires |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Implanted cardiac defibrillator or internal pacing wires |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Aneurysm clip(s) or coils |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Neuro-stimulator |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Implanted drug infusion device (insulin or infusion pump) |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Bone growth/fusion stimulator |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Cochlear, otologic, or ear implant |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Any type of prosthesis (eye, penile, etc.) |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Heart valve prosthesis |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Breast Tissue Expander(s) |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Electrodes (on body, head, or brain) |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Intravascular stents, filters, or coils |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Shunt (spinal or intra-ventricular) |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Vascular access port (Infusaport) |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Any implant held in place by a magnet |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Transdermal delivery system (Nitro or pain medicine patch) |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Retinal Buckle for Retinal Detachment |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Body piercing(s) |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Any metal fragments (shrapnel, bullet, foreign body, etc.) |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Aortic clip |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Wire sutures or surgical staples |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Harrington rods (spine) for Scoliosis Correction Surgery |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Metal rods in bones |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Joint replacement _____ |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Bone/joint pin, screw, nail, wire, plate |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Hearing aid (Remove before MRI) |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Dentures (Remove before MRI) |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Claustrophobia |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Anxiety |

Please mark on the figure below, the location of any implant, or metal inside of, or on your body.



Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material.

Reviewed by: TDI Staff

Front Desk Staff Initials: _____

Medical Assistant Initials: _____

MR Technologist Initials: _____

**NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS DURING THE MRI EXAMINATION.
(Please continue to the other side of this form.)**

For All Patients:

1. Do you have any drug allergies? No Yes

If "Yes", please list: _____

2. Have you ever had a reaction to contrast material (dye) for ANY medical test? No Yes

If "Yes", what test did you have? _____

Describe the reaction: _____

3. Please circle any of the conditions you have or have ever had:

- | | | | |
|-------------------|----------|--------------------|---------------------|
| Kidney disease | Diabetes | Multiple myeloma | Lupus |
| Kidney transplant | Dialysis | Sickle cell anemia | Cancer/tumor |
| Kidney failure | Stroke | Heart failure | High blood pressure |
| One kidney | Asthma | Tuberculosis | |

4. Have you ever worked with metal (grinding, fabrication, etc.) or have you ever had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings or metallic foreign body)? No Yes

5. If you answered "Yes", was the metallic object removed by a physician? No Yes

6. If you answered "Yes", were you told by the physician that he/she removed all of the metal? No Yes

For Female Patients:

1. Are you or could you be pregnant or experiencing a late menstrual period? No Yes

Date of last menstrual period: ____/____/____

2. Are you breastfeeding? No Yes

Signature of Person Completing Form

Date: ____/____/____

Form completed by: Patient Other: _____

TDI Employee Reviewing MRI Safety Form

Date: ____/____/____